Member Change Request Form

CMSP **Fax to 858-578-2135**

***=Mandatory Fields.**

TYPE OF CHANGE (Please check) ☐ **Add** **CARRIER HQ: CMSP1/CMSP2**		
Requester:	**Phone: ( ) -**	**Fax: ( ) -**
Email:	**Title:**	**Date: / /**

MEMBER INFORMATION

***Effective Date: / /**					
***Street:**					
***Address Con't:**					
***City:**					
***State:**			***Zip:**		
County Name:					
***County Code:**			***Aid Code:**		
Relation/ Person Code	***Last Name**	***First Name**	***Gender =M/F**	***DOB**	***Member CIN#**
Ins/01				**/ /**	
***Does this member have a SOC requirement?** ☐ **Yes** ☐ **No**					
Comments:					

Solano and Sonoma Counties Only: To expedite processing, do not wait for the CIN# to be issued before submitting this member add form to MedImpact. Please fax immediately and no greater than 1 hour from granting of eligibility to MedImpact.

Acceptance Agreement: County Medical Services Program is solely responsible for ensuring the accuracy of eligibility information provided to MedImpact and shall be obligated to pay MedImpact for claims accepted by MedImpact that are submitted by or on behalf of persons included on any eligible information provided to MedImpact. My signature below affirms that the information on this form is complete and accurate to the best of my knowledge.

X_____ Date: __/__/__

Signature of Authorized Plan Representative Required